COMPREHENSIVE PERINATAL SERVICES PROGRAM
COMBINED POSTPARTUM ASSESSMENT

Name:_____ **DOB:**_____ **Date:** _____ **I.D. No.**_____

Health Plan:_____ **Provider:** _____ **Delivery Facility:** _____

Anthropometric:

1. Height ____ 2. Desirable Body Wt. _____ 3. Total Pregnancy Wt. Gain _____ 4. Wt. this visit _____

5. Prepregnant wt. ____ 6. Postpartum Wt. Goal _____ 7. Weeks Postpartum this Visit _____

Biochemical:

Blood: Date Collected: _____

8. Hemoglobin: _____ (<10.5) 9. Hematocrit: _____ (<32) Other: _____

Urine: Date Collected: _____

10. Glucose: + - 11. Ketones: + - 12. Protein: + - Other: _____

13. Blood Pressure: ____ / ____ Comments: _____

Clinical - Outcome of Pregnancy:

14. Date of Birth: _____ 15. Gestational Age: _____ 16. Pregnancy/Delivery Complications: _____

17. Birth Weight:(gms) _____ 18. Birth Length (cm): _____

19. Current Weight: (gms) _____ 20. Current Length(cm): _____ Apgar Scores: 1 min: 5 min:

21. Type of Delivery: (circle) NSVD VBAC Vacuum Forceps C-Section (Primary or Repeat) (LTCS or Classical)

Maternal:

22. Have you had your postpartum check up? oYes Date:

oIf No, when scheduled? _____

23. Any health problems since delivery? oYes oNo

If **YES**, please explain: _____

Infant:

24. Has infant had a newborn check-up?

If No, when scheduled? _____

If Yes, any Problems? _____

25. Number of NICU Days: _____

26. Infant exposure to: (circle all that apply)

Tobacco Alcohol Drugs

Nutrition:

27. **Maternal Dietary Assessment:** For ____ Day(s)

Food Group	Servs./ Points		Suggested Change
Protein	____	+ -	____
Milk Products	____	+ -	____
Breads/Cereals/Grains	____	+ -	____
Vit. C-rich fruit/veg	____	+ -	____
Vit. A-rich fruit/veg	____	+ -	____
Other fruit/veg	____	+ -	____
Fats/Sweets	____	+ -	

Dietary Goals:

Client agrees to:

REFERRALS: o WIC Date Enrolled: _____

o Food Stamps o Emergency Food o AFDC

Diet adequate as assessed: o Yes o No Excessive: o Caffeine

28. **Infant**

Method of Feeding: o Breast o Bottle o Breast & Bottle # Wet diapers/day? _____

Type of Formula: _____ With Iron? o Yes o No _____ oz.. _____ times/day

Psycho-Social

29. Do you feel comfortable in your relationship with your baby? o Yes oNo _____
    Any special concerns? _____
30. Are you experiencing post-partum blues? oYes oNo _____
31. Have your household members adjusted to your baby? oYes oNo _____
32. Has your relationship with the baby's father changed? oYes oNo _____
33. Do you have the resources to assist in maximizing the health of you and your baby? oYes oNo
    If "No", indicate where needs exist: oHousing oFinancial oFood oFamily o Other: _____
34. Outstanding issues from Prenatal Assessment/Reassessment: _____

Health Education

35. If breast feeding:
    Do you have enough milk? oYes oNo
    Do you supplement with formula? oYes oNo
    Does your baby take the breast easily? oYes oNo
    Are your nipples cracked and/or sore? oYes oNo
    Do you have any questions about breast feeding? oYes oNo
36. Do you have any questions about mixing or feeding formula? oYes oNo
37. Do you have any questions about your baby's health? oYes oNo
    If "Yes", please explain: _____
38. Do you have any questions about your baby's safety? oYes oNo
    If "Yes", please explain: _____
39. Are you using, or planning to use, any method of birth control? oYes oNo
    If "Yes", which one? _____
    If "No", would you like further information? _____

Plan:

Client Goals, Interventions and Timeline

Client agree to:

Referrals

Agency:_____ Date:_____ Agency:_____ Date:_____

Materials Given:

o	Birth Control	o	Infant Feeding	o	Infant Care	o	Infant Safety	o	_____
o	_____	o	_____	o	_____	o	_____	o	_____

Summary:

Date:_____ Interviewer:_____ Title_____ Minutes Spent:____

Copy of Individualized Care Plan sent to Patient's PCP on: (date) _____ by: (name and title)_____